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Applicability: All DSN Boards, All Financial Managers, All Contracted Service Providers

I. PURPOSE

This document describes the system for funding services used by the South Carolina Disabilities and Special Needs (SCDDSN), hereafter referred to as the "Agency." In all cases, SCDDSN is required by law to serve consumers in the least restrictive environment. Funding for services is subject to changes in the Agency's budget.

II. FINANCIAL MANAGERS

In their administrative role, the Disabilities and Special Needs Boards (DSN Boards), and those grandfathered in as DSN Boards, act as Financial Managers for the majority of community-based services. If approved through a request for proposal (RFP) process through the Budget and Control Board's Materials Management Office, a self-directed support corporation (SDSC) may also act as a Financial Manager for the people for whom the SDSC was established. Funds for community-based services are managed by the applicable county DSN Board or SDSC. The DSN Board either provides the service itself or subcontracts with a qualified provider for the services rendered. The SDSC would not provide service itself, but rather arrange for services and pay the service provider. The Agency, at its option, may contract directly with and pay qualified providers. Qualified providers are those service providers who are qualified through the State Medicaid Agency's service provider enrollment process or through a request for proposal (RFP) process in place through the Budget and Control Board's Materials Management Office. Contracted qualified providers have the option of billing Medicaid directly for Medicaid eligible consumers.

DISTRICT I

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Phone: (864) 938-3497

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DISTRICT II

Coastal Center - Phone: 843/873-5750
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The Agency allocates funds for services in one of two ways: (1) through a capitated system based on funding bands, or (2) through a non-capitated fee for service system.

III. CAPITATED SYSTEM

The funding band system is a budgeting system that assigns one of eight (8) different funding levels to consumers based on their needs. The amount of funding assigned to each level is an average cost of services in each level. Each consumer's needs are different and, as such, the associated costs to fund services to meet those needs vary. The amount of funding attached to a given funding level is not an entitlement; all services provided to a consumer must be based on assessed needs and properly justified in their approved plan. Financial Managers are expected to utilize all available funds to meet the needs of all their consumers. Financial Managers are required to inform the Agency when funds are not available to address identified needs listed in a consumer's current plan. Additional funding is possible through an outlier request system when a consumer's circumstances and needs are substantially higher than the average. Certain threshold levels must be reached before outlier funding may be considered. The outlier request system is described in detail in departmental directive 250-11-DD: Outlier Funding Request System – Capitated Funding System.

There are six (6) residential budgeting levels and two (2) non-residential (persons living at home) budgeting levels. A description of each level follows. The current funds allocated for each level and the outlier thresholds are listed in Attachment A: STATEWIDE INDIVIDUAL FUNDING LEVELS.

A. Residential

Residential funding bands are sufficient on average to cover the following services:

- Residential Habilitation
- Day Services
- Employment Services
- Service Coordination
- Enhanced Supports

The following enhanced supports are included as part of the residential habilitation service definition. The cost for these enhanced supports is included in the residential habilitation reimbursement rate. Payment for the following enhanced supports is the responsibility of the residential habilitation service provider:

- Occupational Therapy
- Physical Therapy
- Psychological Services, which includes counseling and behavior support services
- Speech Therapy

People in residential placements can also receive the following enhanced supports. These enhanced supports are not included as part of residential habilitation service definition. The cost for these services is included in the residential funding band but is not included

in the residential habilitation reimbursement rate. As such, the contracted (QPL) residential service provider is not responsible for the cost of the following services: (Please not that Financial Managers receiving the funding band for residential consumers are responsible for the cost of the following services.)

- Adult Companion Services (only allowed if consumer is living in an SLP I)
- Adult Dental
- Adult Vision
- Audiology
- Assistive Technology
- Prescription Drugs (limit of 2 over the Medicaid State Plan limit)

Transportation to/from day supports is the responsibility of the residential service provider.

The Residential Funding Bands are as follows:

BAND H	<u>Residential Higher Needs</u> Usually consumers residing in: <ul style="list-style-type: none">• ICFs/MR• Community Residential Care Facility – Higher Needs• Community Training Home II – Higher Needs
BAND G	<u>Residential Lower Needs</u> Usually Consumers residing in: <ul style="list-style-type: none">• Community Residential Care Facility – Lower Needs• Community Training Home II – Lower Needs
BAND F	<u>Supported Residential – Enhanced Community Training</u> Usually consumers living in Enhanced Community Training Home I
BAND E	<u>Supported Residential – Community Training Home I</u> Usually consumers living in Community Training Home I
BAND D	<u>Supported Residential – Supervised Living Program I</u> Usually consumers living in Supervised Living Program I
BAND C	<u>Supported Living – Supervised Living II</u> Usually consumers living in Supervised Living Program II

B. Non-Residential, “At Home” Levels

“At home” funding bands are sufficient on average to cover the following services:

- Day Services
- Employment Services
- Service Coordination
- Enhanced Waiver Supports

Transportation to/from day supports for consumers living at home (Band A and Band B consumers) is the responsibility of the day supports provider.

The Non-Residential, “At Home” Funding Bands are as follows:

BAND B Family Supports – Home Supports

Consumers who:

- reside at home and
- are in the MR/RD Home and Community Based Waiver and
- receive Service Coordination and
- receive a combination of Day Services, Employment Services, and/or Enhanced Supports.

Enhanced Supports that may be received include:

- Adult Companion Services
- Adult Dental
- Adult Vision
- Audiology
- Assistive Technology
- Nursing
- Occupational Therapy
- Personal Care I
- Personal Care II
- Physical Therapy
- Prescription Drugs (limit of 2 above State Medicaid Plan)
- Psychological Services, including counseling, and behavior support services
- Respite
- Speech Therapy

BAND A Family Supports – Day Services or Employment Services only

Consumers who:

- reside at home and
- receive Day Services or Employment Services and
- may or may not receive service coordination.

C. Outlier Thresholds

When a consumer's circumstances and needs are substantially higher than the average, additional funding is possible through an outlier request system.

Residential Band H – Consumers whose budgets exceed the outlier threshold may be considered for outlier status.

At Home Band B – Consumers whose budgets exceed the outlier threshold may be considered for outlier status. The majority of the approved outliers are for people with high levels of nursing service needs.

When a consumer is given outlier status, the Financial Manager is given funding in addition to the funding band to cover the cost of the approved higher level of services. If the consumer is designated as needing a residential outlier and is served by a contracted qualified provider, the additional approved funding will be added to the contracted qualified provider's reimbursement rate.

IV. NON-CAPITATED SYSTEM

The non-capitated system pays the Financial Manager for specific types of services, rather than for groups of services. The services include:

- For people with Mental Retardation – Related Disabilities or Autism: Service Coordination (for those not assigned a funding band), Respite (for those not enrolled in the Home and Community Based Waivers), Individual Rehabilitation Supports, and Early Intervention.
- For people with Head and Spinal Cord Injuries: Service Coordination, Supported Employment, Individual Rehabilitation Supports, Residential Habilitation, Day Habilitation, Prevocational Services, and Respite.

V. HOW CHOICE WORKS WITH THE FUNDING SYSTEM

A request for proposal (RFP) process is in place through the Budget and Control Board's Materials Management Office to increase the choices available to consumers by identifying and approving providers of services. When a consumer is satisfied with the current services and supports he/she is receiving, it is likely that no changes will be made. However, when services are necessary, justified by an assessment, included in the consumer's approved plan, and the consumer desires another service provider, the consumer may select another service provider from the Qualified Provider List. Funding follows the consumer if he/she elects to change service provider. If another service is appropriate to meet a consumer's needs, he/she may opt for the other service and then select a contracted qualified provider to provide the new service.

If a consumer chooses another contracted qualified provider, the Financial Manager will:

- document the consumer's/guardian's choice of a qualified provider,
- obtain the consumer's/guardian's permission (through signature) to transfer the original file and related information specific to the service being delivered, and
- transfer the original file and all related information to the selected qualified provider.

The Financial Manager will receive the band payment or other funding allocated to the consumer. If the qualified provider elects not to bill Medicaid directly and instead bills the Finance Manager for Medicaid eligible consumers, the Financial Manager will contract with and pay the qualified provider upon delivery of service and submission of appropriate service reporting information including bills presented. If the qualified provider chooses to bill Medicaid directly for those consumers who are Medicaid eligible, the State Medicaid Agency will make payments directly to the provider of a covered service furnished to an eligible consumer in accordance with Section 1902(a)(32) of the Social Security Act. Any amounts paid by the State Medicaid Agency to a qualified provider will be deducted from the funding band payment to the Financial Manager. The Agency may also contract directly with and pay qualified providers.

VI. ASSIGNMENT OF FUNDING BANDS

A. Analyzing the Data

Every month the Cost Analysis Division will download data from three of DDSN's mainframe applications:

- Consumer Data Support System (CDSS) and
- Service Tracking System (STS) and
- Waiver Tracking System (WVR).

The Cost Analysis Division will run different queries and reports and analyze the data.

- Residential reports will be produced to determine who has moved into or out of a residential placement and if a funding band needs to be assigned or changed. In addition, the Cost Analysis Division will sign off on all residential admission/discharge/transfer forms. The form with all approvals will be scanned into a PDF file and sent to the residential service provider. The form indicates what funding band will be assigned to the consumer when he/she moves. If the consumer is moving to a service provider from the Qualified Provider List, the form will also indicate what rate will be paid.
- Reports will be produced to determine which consumers have been enrolled in an "at-home" family support waiver slot and have an approved budget. The reports will also indicate which consumers have been terminated from an "at home" family support slot. Band B funding is provided from the month the waiver budget starts through the month the waiver budget ends. If the consumer attends

center-based day supports and that service is in his/her waiver budget, a day program slot will be awarded.

If the consumer initially does not receive center-based day supports (a slot was not awarded) but later started receiving center-based day supports, a day program can be requested at that time.

- Other reports will indicate which consumer living “at home” receives day supports funded either by facility-based rehabilitation support, state funds, or other. It will indicate who has been admitted or discharged from center-based supports and supported employment. Consumers’ Band A funding designations will be made as appropriate. This does not affect the amount of funding received but it does indicate if a provider has vacancies or is over-enrolled.

B. New Residential Admissions

Consumers moving from “at home” in the community will be automatically funded at the following levels unless otherwise justified.

- Band G level for ICF/MR, CRCF, and CTH II placements or
- Band C level for SLP II placements or
- Band D level for SLP I placements or
- Band E level for CTH I placements or
- Band F level for Enhanced CTH I placements

In accordance with departmental directive 502-01-DD: Admissions/Discharge of Individuals to/from DDSN Funded Community Residential Settings, only those consumers pre-approved by Agency officials for residential admission will be funded.

Funding Band Changes: If the residential service provider feels a different funding band level is warranted, the residential service provider must provide detailed justification along with supporting documentation (behavioral support plan, behavioral data, or the annual plan). This justification must be submitted to the District Office along with the Community Residential Admissions/Discharge Report.

Outlier Funding: If the residential service provider feels outlier funding is warranted, the residential service provider must submit the “Initial Request for Outlier Funding” to the District Office.

C. Residential Transfers


Consumers moving from Regional Centers or Alternative Placements will be funded at the following levels:

- Band H level for ICF/MR, CRCF, and CTH II placements or

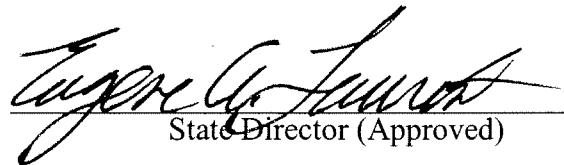
- Band C level for SLP II, Band D level for SLP I, Band E level for CTH I, and Band F level for Enhanced CTH I.

SLP II, SLP I, CTH I and Enhanced CTH I consumers moving to more restrictive placements in CTH II's, CRCF's, and ICFs/MR will be funded at the Band G level unless otherwise justified.

Consumers moving to SLP II, SLP I, CTH I, and Enhanced CTH I placements will be funded at the funding band level appropriate for that type of residential placement



Deputy State Director,
Administration (Originator)



State Director (Approved)

RELATED POLICIES: 250-11-DD, 502-01-DD

ATTACHMENT: A. STATEWIDE INDIVIDUAL FUNDING LEVELS

ATTACHMENT A

SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
STATEWIDE INDIVIDUAL FUNDING LEVELS - EFFECTIVE MARCH 1, 2009

	Annualized Funding
Band A Day Supports Only - Non Waiver Funded	\$ 9,062
Band B At Home Waiver Supports	\$12,471
Band C Supported Residential - SLP II	\$28,161
Band D Supported Residential - SLP I	\$17,868
Band E Supported Residential - CTH I	\$22,093
Band F Supported Residential - Enhanced CTH I	\$35,932
Band G Residential Low Needs	\$53,927
Band H Residential High Needs	\$73,634

Outliers:

Residential Band H - Consumers whose budgets exceed \$93,509 are considered for outlier status.

At Home Band B - Consumers whose budgets exceed \$27,883 are considered for outlier status. The majority of the approved outliers are for consumers with high levels of nursing service needs.

NON CAPITATED SERVICE COORDINATION RATE

Revised

Per consumer on active service coordination

\$ 1,497

Per month

\$124.75